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EDITORIAL

Touching the Patient

Rob Nied, MD

At the 2014 Australian Open, Stan Wawrinka became the first man since 2009 to win a Grand Slam tennis tournament outside the Big Four of Federer, Djokovic, Murray and Nadal. In the championship match, he beat Nadal, who was suffering from a back injury. How much low back pain factored into the loss, only Rafa knows for sure. Certainly the 90% of us who have experienced this type of pain can imagine how limiting it might have been. In fact, low back pain is the number one cause of disability in the United States, with an estimated $100 billion annual cost for lost work and wages. For Nadal, the difference between the winner and first runner-up prize money was $1.3 million.

Does sports participation cause low back injuries? A recent study reviewing injury data from professional tennis players competing in the US Open from 1994 to 2009 did not find a significant increase in low back injuries, despite increases during those years in game intensity, higher rotational velocity serves, and longer playing seasons.[1] In fact, NCAA injury surveillance has found that only 2% of all sports-related injuries in college athletes are to the low back. Some of these are traumatic injuries, such as contusions and spondylolysis, but most often athletes suffer from the same common mechanical low back pain as the rest of us.

Degenerative disc disease may be quite common in athletes. In a study of asymptomatic late adolescent elite tennis players, none of whom had a history of low back pain, 28 of 33 athletes had significant findings on MRI, including pars interarticularis lesions, facet arthropathy and bulging discs.[2] Does this mean that sports are particularly hard on the spine or that a "bad back" on imaging does not necessarily correlate with symptoms or athletic limitation? Knowing how common abnormal MRI findings are in the general public, my interpretation is that athletes have the same backs as the rest of us but are better able to control their core forces and motion.

Dr. Nied, a family and sports medicine physician at Kaiser Permanente Santa Rosa, is the immediate past president of SCMA.

Athletes like a hands-on approach to low back pain. They are very aware of their bodies, and manual therapies tend to work well for them. Deep tissue work and massage have become a standard part of most training regimens. Beyond just "feeling good," animal research suggests that manual therapy may actually help injured tissues recover faster. In a 2013 *Consumer Reports* survey, of the 14,000 subscribers who had experienced low back pain in the past year but did not have back surgery, 59% were highly satisfied by the care from their chiropractor, 55% with their physical therapist, and 53% with their acupuncturist.[3] Only 34% of respondents were highly satisfied with the treatment offered by their primary care physician. Clearly our patients also appreciate the hands-on healing power of touch—it is better than prescribing a pill.

Sports medicine, as it relates to low back pain, lies somewhere between the primary care physician and the expert physiatrists and spinal surgeons who share their perspective and knowledge in this issue of *Sonoma Medicine*. A primary care colleague recently reminded me that "Sports medicine docs aren't really much better at diagnosing or treating back pain, but they *are* better at helping the patient understand what is going on."

Understanding the biomechanics of low back pain, and being able to express this in language meaningful to the patient, alleviates much anxiety and may help avoid advanced imaging done simply to satisfy the patient's need to "know what is going on." As Dr. Waddell and others have pointed out, however, a solely mechanistic approach to low back pain is incomplete at best.[4] Few athletes are malingering, but their overall psychic and emotional state contributes greatly to their perceived disability.

Perhaps this situation is where a sports medicine perspective is most valuable. Our goal is to keep people active and involved in the things they love doing. Fortunately we tend to have motivated patients, but that motivation needs to be corralled, redirected, managed and applied. The successful physician finds a similar motivation in every patient. Focus on functionality, not always on cure. And don't forget to touch the patient. ◇

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Going from Red to Green with Our Patients

Kirk Pappas, MD

In thinking about how we physicians should be treating low back pain, I'm reminded of the closing line of "Won't Get Fooled Again" by The Who: "Meet the new boss, same as the old boss." In the last 15-20 years, not much has changed in what we can do for low back pain. We can, however, ask ourselves how well are we doing from the larger perspective of our Hippocratic Oath.

If your graduation day from medical school is difficult to recall, the modern version of the oath speaks to our patients' experience with low back pain: "I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug." Sadly, instead of fostering that empathic relationship with our patients—in which we collaborate and make informed choices about their often chronic condition—we have given a tremendous amount of back pain care to the tune of $86 billion a year and still not improved patient pain outcomes.[1]

One factor contributing to our lack of progress in treating low back pain is the messaging around pain that our patients receive from mass media. They are bombarded with commercials about "medications that cure," advertisements in the back of airline magazines for "Band-Aid laser surgery," and even hour-long infomercials on late-night TV describing the benefits of specific devices that will "take away your back pain." None of these gimmicks is supported in the literature, nor do they help our patients live better. All they do is encourage patients to spend even more money looking for that miracle cure.

Dr. Pappas, a physiatrist, is physician in chief at Kaiser Permanente Santa Rosa.

How can we physicians take back our power and put this propaganda in its place? We are in a unique position to earn and maintain the trust of our patients. In fact, research has clearly identified what patients with low back pain want from us. In a landmark 1986 study, Deyo and Diehl found that "The leading reason for patients feeling dissatisfied with their care was their belief that the doctor's explanation of the problem was inadequate."[2] Second on the complaint list was that "Patients said they did not understand what was wrong with their back at the end of the visit."

We must heed the conclusions from this nearly 30-year-old study and understand that what patients truly want is an honest conversation about their condition, a thorough evaluation and a confident treatment plan. Patients also want to know that we empathize with their experience of pain. A 2008 report found that managing patients' expectations, addressing psychosocial factors, expressing empathy and explaining each patient's condition were all necessary for a successful experience for patients with low back pain.[3]

When I attended medical school in the 1980s, we were taught that low back pain was a self-limiting condition. In other words, it would go away, get better on its own, and never come back. I learned a valuable lesson the next time I saw a patient return with low back pain. From that day forward, I took a different view of conventional wisdom because what my patients experienced was the opposite of what I told them.

Von Korff and Saunders proposed a better and more accurate description of low back pain in 1996: "The natural history of nonspecific low back pain … is a recurrent problem."[4] When we see patients with mechanical low back pain, we need to be honest with them and say there is a likelihood that it could recur. Seems so simple, right? But for some of us, it's easier said than done (like trying to play the guitar as well as The Who's Pete Townshend).

How can we overcome our own barriers to advancing the care of patients with low back pain? As a physiatrist, I find that having a strategy helps. What follows is a strategy for getting our patients "from red to green."

Figure 1 shows guidelines for assessing "red flags" in patients with low back pain. Addressing these red flags by studying the patient's history can guide us forward in their care. The key red flags, which may require imaging and interventional care, are history of cancer, fever, chronic use of corticosteroids, symptoms of cauda equina syndrome, and radiculopathy (referred pain from back to leg below the knee).

The guidelines were issued by HEDIS (Healthcare Effectiveness Data and Information Set) in 2006 with respect to imaging for low back pain. HEDIS found that "Low back pain imaging before 28 days and without any red flags is unlikely to result in any benefit to the patient."[5] The National Committee for Quality Assurance is using these guidelines for patients 18–50 years old to increase quality in pay-for-performance plans for physicians and health insurers.

Figure 1. Red flag signs of possible causes of back pain

Cancer
- **History of cancer***
- Unexplained weight loss
- Age > 50
- Failure to improve with therapy
  Pain for 4-6 weeks
- Rest pain

Fracture
- **Use of corticosteroids***
- Age > 70
- History of osteoporosis
- Recent trauma

Radiculopathy
- Leg pain below the knee
- +SLR

Infection
- **Fever***
- History of IV drug use
- Recent bacterial infection (especially urinary tract infection, skin or pneumonia)
- Immunocompromised state (steroid use, organ transplants, diabetes, AIDS)
- Rest pain

Cauda equina syndrome
- Urinary retention (or incontinence)
- Saddle anesthesia
- Anal sphincter tone decrease (incontinence)
- Bilateral lower extremity weakness/ numbness or progressive neurological deficit

*Most important single red flag for condition

SOURCE: Kaiser Permanente

Extra-spinal generators of mechanical low back pain are not quite red flags, but they should be part of patient evaluations. They include kidney stones, gallstones, aortic aneurysm and even intra-abdominal infectious conditions. As a physiatrist, I often connect with my adult and family medicine colleagues for advice on work-ups for these conditions.

Figure 2 shows the "yellow flags" associated with mechanical low back pain. These are the psychosocial risks of delayed recovery that need to be identified. Identifying these yellow flags is as important as recognizing red flags. In my experience, it's much harder to manage the yellow flags than the red ones. By addressing the yellow flags, however, we can help our patients get to "green" and advance their care.

Yellow flags are best understood by thinking of yellow lights in driving: yellow means "slow down." Failure to identify yellow flags can lead to patient dissatisfaction and often results in imaging and medications that neither guide nor help us. Once you identify yellow flags, what works best is getting support for patients from behavioral medicine specialists, such as psychologists and social workers (MSW, LCSW).

On physical examination, Waddell's Signs can help us identify yellow flags (see Figure 3). Gordon Waddell has studied these signs for more than 30 years, and his team has updated the guidelines many times. Patients with yellow flags can also have red flags, but once the red flags are ruled out, the yellow ones need to be addressed.

The next step in treating low back pain is to get ourselves and our patients to green. As Deyo and Phillips observed in 1996, "Patients want anatomic explanations, and although we understand that there are important psychosocial factors that amplify or prolong pain, patients still need reassurance that the doctor understands what is going on in the back, why they are having pain, and that the doctor is confident that additional diagnostic tests are not needed."[6]

We can earn trust around these expectations by adopting three strategies:

- Making an evaluation that includes not only our history (where we identify and rule out red flags and address yellow ones), but also a physical exam. A skillful exam that lays on hands builds a relationship of trust and shows that the physician cares and has the knowledge to ascertain the pain generator and provide appropriate treatment.
- While not supported in the literature, I have found that touching patients where they hurt as part of the physical exam helps to earn trust.
- Using clear language to describe patients' likely pain generators.

There are many pain generators in the lower back, including muscles, joints, ligaments, nerves and discs. Unfortunately, we do not have any tests or procedures that validate which of those pain generators are producing the pain. We can, however, understand the effect of nociceptive nerve endings, which fire when activated by pain generators. The nociceptive flexion reflex then creates spasms and decreases the range of motion while increasing the pain. This is the most accurate physiologic description of how pain is generated in the back. To explain this process to patients in language that earns trust, my go-to statement is, "Your muscles and joints are inflamed, and this is causing the pain. In response, your body wants to move less."

At that point, it's important to pivot and advise patients to stay active. Helping our patients get to green involves asking them to move their bodies despite the pain. According to guidelines from the American College of Physicians and the American Pain Society, bed rest and prolonged rest produce reconditioning and cause patients to take twice as long to get better for each

day they have decreased their activity.[3] The guidelines state that the most important, valuable, and scientifically supported treatments for mechanical low back pain include:

- Advice to remain active.
- Superficial heat.
- Over-the-counter medications (adjusted by the physician for the patient's medical condition).

Back pain is ultimately best managed by patients' own self-care, including attention to posture and body mechanics, exercise, nutritional factors, adequate hydration, adequate sleep, a healthy weight, and reduction and management of stress. The physician should be a coach and role model in supporting patients in lifestyle changes.

We could slice and dice every article ever written about our favorite go-to cure for low back pain and discover that most of them are not supported by the literature. That literature is evolving so fluidly that the Cochrane Review is now tweeting on back pain.[7]

This year the two surviving members of The Who (Pete Townshend and Roger Daltry) are touring the country singing the same old songs. As with patients with mechanical low back pain, we can be reassured that the classics still work. Our patients want a relationship that's based on trust and honest communication. Our words are powerful, and we can be encouraging and optimistic to help our patients heal. For mechanical low back pain, it's our duty as physicians to help our patients go from red to yellow to green. ◇

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Figure 2. Yellow flag risk factors for delayed recovery (examples)

- Previous history of instability
- Inconsistent findings
- Abnormal pain behavior
- Litigation
- Work dissatisfaction
- Attention seeking
- Preference for prolonged bed rest
- Depression
- Chemical dependency
- History of abuse
- Family history of chronic pain

SOURCE: Kaiser Permanente

Figure 3. Waddell's signs
(behavioral responses to examination)

- **Tenderness.** Pain elicited from light touch or rolling the skin.
- **Simulation test.** Axial rotation of the pelvis and shoulders, or if light pressure (1–2 lbs.) applied to the head produces spine pain.
- **Distraction test.** A symptomatic response to a test, such as straight leg raising, changes when the test is repeated while the patient is distracted.
- **Regional disturbances.** Cogwheeling during motor testing or non-neuro-anatomic numbness.
- **Overreaction.** Overt pain behavior, such as grimacing, sighing, guarding, bracing, groans, tremors, collapsing, stumbling during routine examination.

Note: Greater than 3 signs present alerts the clinician to evaluate for non-organic factors and potential delayed recovery (it is not diagnostic of malingering).

SOURCE: Main CJ, Waddell G, "Behavioral responses to examination," Spine, *23:167-171 (1998).*

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* Genworth 2014 Cost of Care Survey, February 2014, https://genworth.com/corporate/about-genworth/industry-expertise/cost-of-care.html, viewed 1/27/15

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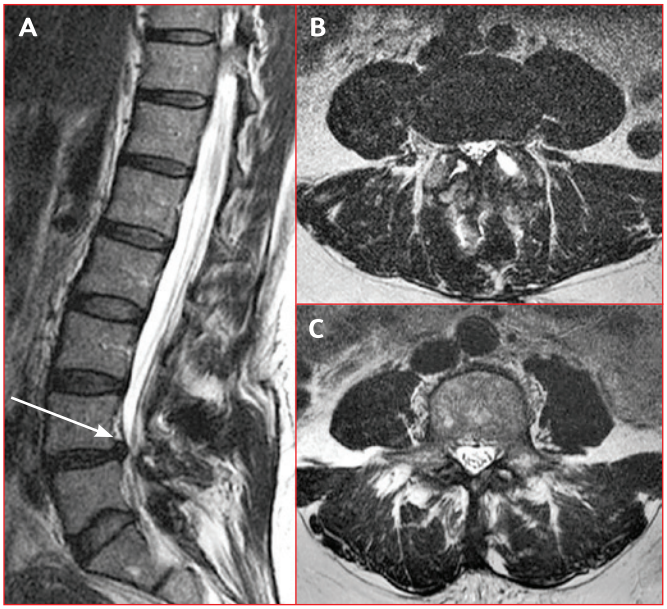
Lumbar Spinal Stenosis

Christian Athanassious, MD



A: Sagittal view of patient with stenosis at L4/L5. B: Facet hypertrophy and ligamentum flavum thickening contributing to central canal and lateral recess stenosis. C: Normal spine without stenosis.

Spinal stenosis is a common disease of the spine that affects people in their 50s, 60s and beyond. As the average lifespan increases over the next 20–30 years, the incidence of this disease will increase as well. Spinal stenosis is a progressive disease that may become more severe as people age. This increase in severity slowly decreases their quality of life, along with their ability to ambulate and be self-sufficient. This article discusses the relevant anatomy, pathophysiology, signs and symptoms, physical exam findings, diagnosis, and options for treating spinal stenosis. With appropriate diagnosis and treatment, stenotic patients can regain their optimal quality of life.

Anatomy and Pathophysiology

The anatomy of the spine is relevant to the incidence and progression of spinal stenosis. Generally, there are three shapes present in the spinal canal: circular, oval and trefoil (cloverleaf). Of these shapes, people with a trefoil canal have a higher predisposition for developing spinal stenosis.

Dr. Athanassious, an orthopaedic surgeon, is co-director of the Total Spine Health Program at Santa Rosa Orthopaedics.

Anteriorly, the canal is bounded by the vertebral body, vertebral disc and posterior longitudinal ligament. The vertebral disc is made up of an exterior shell called the nucleus fibrosis, composed of type I collagen and 75% water, and the interior nucleus polposus, composed of type II collagen and 85% water. As people age, the nucleus pulposus dehydrates, making the disc less hydrophilic, less tall and less flexible. Age also increases the type I collagen content, making the unit less ductile. The nucleus fibrosis fissures, the structure weakens and the disc buckles. In addition to the above changes, osteophytes may develop across the disc space, which can cause further compression of the nerve roots. The additive effects of these changes may shrink the size of the vertebral canal and the nerve roots that innervate the lower extremities.

Lateral and posterior elements of the spine may also contribute to spinal stenosis. For instance, some patients may have congenitally shortened pedicles, predisposing them to the disease. Degenerative changes, such as osteophyte formation and facet hypertrophy, may develop in the articular facets. Loss of height can lead to further overlap of the superior and inferior facet, causing foraminal stenosis. Loss of height, in addition to flavum hypertrophy, may also increase the redundancy of the ligamentum flavum, which decreases the space in the canal. The additive decrease in space of the anterior, lateral and posterior elements contributes to the pathophysiology of spinal stenosis.

Other causes for spinal stenosis include spinal spondylolisthesis (slippage of the vertebral body in the

anterior-posterior direction) and/or congenitally shortened pedicles. Patients with spondylolisthesis suffer from dynamic, linear and rotational instability. The posterior elements of the cephalad vertebrae create central and lateral recess stenosis when they "slip" forward on the anterior body of the caudal vertebrae. This pathology is more common in women, often at the L4/L5 level.

Congenital stenosis may predispose patients to suffer from spinal stenosis. Some people have shortened pedicles and decreased interpedicular distance. All of the above may contribute to the development of spinal stenosis.

Signs and Symptoms

A broad range of factors can lead to spinal stenosis and create symptoms. Studies have shown, for example, that a >45–50% decrease in the volume of the canal and/or a sustained 10 mmHg increase of pressure within the canal may cause permanent damage to the nerve roots.[1] This damage may occur from a change in vascular patterns, a release of chemical mediators and/or a direct insult to the nerve roots.

Although many patients will develop changes in their spines consistent with spinal stenosis, not all will manifest the disease clinically. The natural course of the disease is slow and progressive. About 50% of patients who develop symptoms will have a significant impact in their activities of daily living.[2] The risk of rapid onset paralysis is rare; if this occurs, other possible causes must be investigated.

Many studies have focused on the natural history of the disease in an effort to determine which patients are at risk for worsening symptoms. Roughly one-third of patients will have improvement during their clinical course, one-third will be unchanged, and one-third will become worse.[3] Unfortunately, the data are unclear on which patient will fall into which category.

Spinal stenosis patients may present with complaints that involve the back or legs. They may complain of being unable to stand up straight, and they may be more comfortable standing crouched forward or leaning on a cart or similar object. Patients may complain of unilateral or bilateral burning pain that descends from the buttock to the foot. The pain may worsen the longer they walk or stand, or walk downhill. They may also describe a decrease in sensation, a weakness in the legs or a change in gait. Central stenosis generally does not affect a specific nerve distribution, but lateral-recess or foraminal stenosis may. The most common nerve root affected is in the L5 distribution.[4] Patients may also suffer from back pain in addition to or separate from leg pain. The pain is usually in the lower back radiating to the buttock.

Physical Exam and Diagnosis

The physical exam should include evaluating the patient's posture. Spinal stenosis patients will often complain when their back is placed and held in extension. If patients have weakness in the L5 myotome, they may have a foot slap or a high-step gait when walking. A full musculoskeletal exam must be performed to look for pain on passive motion of the hips, contracture, weakness, sensory deficits and asymmetric changes in reflex. Physicians should also evaluate for sustained clonus, difficulty walking, broad-based gait, loss of bowel or bladder function, and decreased sensation in the "saddle" region as these may be signs of other disease.

Radiographic studies should only be used as an adjunct to the diagnosis of spinal stenosis. Patients who describe more than 30 days of back pain should have a standing AP/Lateral XR of the lumbar spine. If patients are found to have scoliosis or spondylolisthesis, a full-length standing AP/Lateral XR may be appropriate. Standing flexion and extension XR may be beneficial to understanding the dynamic compression and instability that may be present in a patient. MRI is an excellent modality for evaluating central canal, lateral recess and/or foraminal stenosis.

CT or CT myelogram is beneficial for patients who are unable to have an MRI, or if the doctor wants to gain further understanding of the patient's pathology. However, CT scans produce a substantially high load of ionizing radiation. Many asymptomatic people in this older population may have spondylosis, decreased disc height, and spinal stenosis seen on imaging and require no treatment.

Non-Surgical Therapy

Most patients suffering from spinal stenosis should have a trial of non-surgical therapy.[5] The appropriate modality depends on the patient's physical status, symptoms and severity of disease. Analgesics such as acetaminophen are an excellent modality with low risk to the patient. In fact, acetaminophen may be a better option for patients in their 50s and 60s because it offers a lower risk profile than NSAIDs, with a similar benefit.

Physical therapy focusing on limiting lordosis of the spine and strengthening the core is also beneficial. Therapy should also focus on limiting knee and hip contractures, which may increase lordosis. Transforaminal epidural injections may be warranted if a patient has severe symptoms.

In most cases, no adverse effects are seen in patients who engage in a short period of non-surgical therapy before deciding if surgical intervention is appropriate. For patients who are unable to participate in therapy or surgery, a brace and/or walker may be of benefit.

Surgical Therapy

Surgical therapy may be required and beneficial in up to 20% of patients suffering from spinal stenosis. On presentation, some patients may have weakness, an inability to ambulate and/or a motor deficit. These patients may require surgical treatment sooner than patients with mild to moderate symptoms, such as numbness and paresthesia. On the other hand, some patients may have loss of bowel or bladder continence and/or a progressive motor deficit. They may require immediate treatment.

Many studies have shown that surgical treatment offers faster, longer-lasting and improved outcomes in patients with moderate to severe symptoms of stenosis.[3] Surgery involves identifying the area of stenosis and decompressing it. In some cases, the patient may have a combined instability and stenosis that should not be treated by decompression alone because decompression may further destabilize the spine and lead to more back and leg pain. This specific group of patients may require a decompression and fusion of the stenotic segment of the lumbar spine.

Decompression can be performed by using a surgical microscope or loop magnification. Additionally, decompression may involve a laminotomy and a partial facetectomy. Operative treatment, when appropriately indicated and performed correctly, can give improvements to more than 60% of patients for more than four years.

In summary, spinal stenosis is a common disease of increasing incidence. The disease may progress and slowly affect a patient's quality of life. As physicians, we should think about this disease in older people who complain of leg and/or back pain and say that they can only walk short distances. Appropriate diagnosis and management can keep these patients walking, active and comfortably performing the activities they enjoy. ◇

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Malingering in Patients with Chronic Pain

Anish Shah, MD, and Alex Kettner, PsyD

Malingering, also known as symptom fabrication, may occur in a striking 20-40% of patients presenting with chronic pain.[1] Malingering is defined as a condition where a person intentionally exaggerates physical or psychological symptoms for external incentives, such as obtaining financial compensation, avoiding work, obtaining medication, eluding criminal prosecution or avoiding military duty.[2–4]

Some people believe that malingering typically occurs for potential financial gains, but statistics show that it usually does not result in compensation. Studies have found that 82% of disabled people living in the United States have more financial difficulties than when they were working; the financial status remained about the same for 17%; and only 1% experienced financial gains.[2,5] Other studies have shown that some patients assume a "sick role" for several reasons:[1–3]

- Weighing the cost/benefit of malingering.
- Not recognizing a better alternative.
- Wanting to avoid work-related stress.
- Dissatisfaction with a current position.
- Trying to obtain medication.
- Trying to receive the medical coverage that often accompanies disability benefits.

Dr. Shah is a Santa Rosa psychiatrist. Dr. Kettner is a clinical psychologist in the town of Napa.

Two nationwide surveys in the 1990s found that 20% of Americans believed fabricating symptoms for workers' compensation claims was acceptable.[6,7] These cases often prompt malingering because of the medicolegal aspects and the financial incentives. Similarly, a 2002 survey of 144 neuropsychologists who performed medicolegal evaluations reported that 33% of injured patients with chronic pain engaged in malingering.[1]

Despite the fairly high incidence of malingering among disability claimants, distinguishing patients who are fabricating symptoms from those who truly have chronic pain remains a significant challenge. This difficulty may be due to the complex and time-consuming nature of such assessments; concerns that the clinician may have regarding the potential legal liabilities of a misclassification; or the stigmatization that a diagnosis of malingering may cause the patient.

Clinicians face additional obstacles because the doctor-patient relationship cannot be upheld in such cases. The assessment is based primarily on self-reported data, and the patient's credibility is brought into question, which often leads to an exaggeration of reported symptoms. Obstacles such as these raise the question as to how clinicians, who serve as qualified medical evaluators (QMEs) in such cases, can effectively perform objective evaluations.

QMEs are clinicians who have received certification from the Division of Workers' Compensation Medical Unit to evaluate the potential disability of injured workers and submit medicolegal reports. The final reports are used to determine whether or not an injured worker is eligible to receive workers' compensation benefits. Certified QMEs include physicians, psychologists, chiropractors, optometrists, dentists, acupuncturists and podiatrists. Medical doctors must be board certified in their specialty, recognized by the Industrial Medical Council (IMC) and the Medical Board of California, and have completed a residency training program. In general, psychologists must hold a doctoral degree in psychology, be board certified in clinical psychology, and have at least five years postdoctoral experience in diagnosing and treating emotional and mental disorders.

According to the DSM-IV-TR, patients who are suspected of fabricating symptoms typically display the following behavioral and emotional patterns:[4]

- Symptoms that are presented in a medicolegal manner.
- Marked discrepancies between the

reported symptoms or disability and the clinical findings.

- Failure to cooperate during the evaluation or to comply with the prescribed treatment regimen.
- Presence of symptoms that are associated with antisocial personality disorder.

Conversely, criteria that clinicians can consider when diagnosing patients with true chronic pain include:

- Observation that the patient has received intensive treatment for the injury.
- Objective corroboration of the reported symptoms and the diagnostic evaluation.
- Patient has suffered obvious and significant personal and financial losses.
- Presence of self-defeating behavior.

Additionally, malingering has to be differentiated from conditions such as undetected or underestimated physical illness, somatoform disorders, and factitious disorders that present predominantly physical symptoms.

When a clinician is evaluating a potential malingering case, the diagnosis is mainly based on whether other factors that may be contributing to the patient's condition can be excluded. Therefore, a critical factor that must be ruled out is an undetected or underestimated physical illness. Similarly, somatoform disorders are associated with symptoms of a psychological etiology that are not fabricated or exaggerated, thereby excluding such disorders from malingering. Conversion disorder, also classified under the somatoform category, generally results in true physical symptoms, such as voluntary or sensory deficits attributed to psychological and neurological factors.[4] Hypochondriasis, although somewhat psychological in nature, is based on a patient's misrepresentation of one or more actual symptoms, thereby excluding this condition from malingering as well.[4]

In contrast to undetected or underestimated physical illnesses and somatoform disorders, factitious disorders are characterized by physical signs and symptoms that are intentionally exaggerated and in some cases, fabricated in order to assume or maintain the "sick role."[4] Presentation of symptoms may include fabrication of pain from a nonexistent or self-inflicted condition, as well as exacerbation of a preexisting medical condition. External incentives, such as financial gain or the avoidance of legal persecution, are absent in patients who present with factitious disorders; this factor renders the presence of such conditions as an exclusion to malingering.

Clinicians must also consider how social and cultural factors influence the presentation of illness-related behavior. Research indicates that sociocultural factors can affect the way patients display symptoms.[8,9] Pain-related behavior, for instance, is displayed dramatically in some cultures and stoically in others. Therefore, a perceived exacerbation of symptoms should not be immediately deemed as a sign of malingering

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without applying additional differential diagnostic criteria.

In order to circumvent some of the obstacles that clinicians face as QMEs, California and some other states use the Frye standard to help clinicians select the appropriate malingering assessment methods and tools. Furthermore, a QME's testimony must meet the Frye standard to be admissible as evidence in civil, criminal, disability and workers' compensation cases. Meeting the Frye standard may guide a judge's decision regarding the validity of the expert's testimony.

According to the Frye standard, an expert's testimony should be based on reasoning and a methodology that is generally accepted within the scientific community. The following criteria have been established in this regard:[10,11]

- Is the witness qualified to be an expert?
- Is the underlying scientific premise generally accepted?
- Is the evidence that has been presented based on a testable theory or technique that is falsifiable and refutable?
- Has the scientific evidence been sufficiently tested and accepted by the relevant scientific community?
- Has the theory or technique been subjected to peer review?
- Is there a known error rate for the assessment?

Based on these criteria, if a QME uses an assessment that does not have supportive evidence from peer-reviewed studies or methods, a Frye challenge may arise—although the standard of evidence in California is reasonable medical probability. Nonetheless, a challenge limits the types of assessment tools that a QME can choose. This limit may serve as a guide toward the best choice.

Back pain is a common chronic condition that may motivate some patients to engage in malingering. Chronic back pain may arise in the bones, muscles, ligament, tendons and nerves in different parts of the back. The pain may be classified as acute pain that lasts for six weeks or less; periodic or frequent pain that persists for up to three months; or chronic pain that lasts for more than three months.

A number of diseases or injuries may result in back pain. Low back pain is the most commonly reported type, resulting in millions of annual emergency room visits. According to the American Physical Therapy Association, more than 60% of Americans have experienced debilitating low back pain at some point in their lives.[12] Middle and upper back pain are frequently reported as well.

Clinical comparisons of patients with similar degrees of chronic back pain have shown that those seeking compensation often report levels of pain, disability, psychological problems, unemployment and time off work that are significantly higher than back-pain patients not seeking compensation.[13] The amount of time spent seeing doctors for medical reports and lawyers for legal advice appears to augment

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malingering, as well as the idea that rapid recovery would result in a smaller financial settlement.[14] Therefore, in many cases of chronic back pain, the effects of the back injury, the psychological disturbances and the quest for financial compensation often elicit malingering. Through careful observation and examination, QMEs can distinguish true pain patients from those engaging in fabrication.

A complete physical and medical assessment for chronic pain fabrication should adhere to the following guidelines:

- Physical examination that is relevant to the reported chronic pain.
- Patient self-report.
- Structured interview that focuses on variables indicative of possible malingering.
- Review of medical records and diagnostic tests.

If psychological symptoms need to be evaluated, a psychological QME should screen for such symptoms through a comprehensive evaluation that includes a clinical interview, a mental status examination, behavioral observations, data acquisition using standardized psychological tests and, if possible, third-party information. Obtaining information contradicting the examinee's version of events is probably the most accurate means of detecting exaggeration, fabrication or denial, and it may be the only viable evidence with examinees who sabotage interview and testing efforts.[15]

In summary, health care professionals who have taken on the role of QMEs to evaluate malingering should focus their evaluation on searching for compelling inconsistencies in the self-reported, medical and neuropsychological data, in conjunction with reviewing potential motivations or circumstances that may explain illness behavior. QMEs who administer optimal medical and neuropsychological malingering evaluations that follow the Frye standard are best prepared to overcome this challenge. ◇

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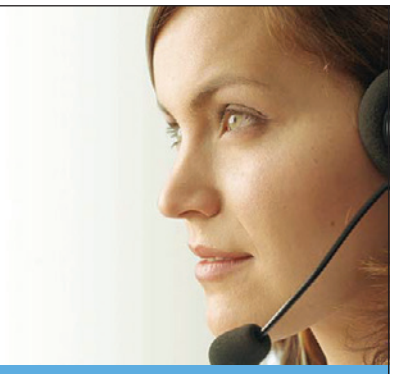

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SCMA President Mary Maddux-González

Steve Osborn

Born at Santa Rosa Memorial Hospital in 1951, new SCMA President Dr. Mary Maddux-González has deep roots in Sonoma County. Her father's family moved to the county in the 1850s, around the same time that her mother's family moved to Napa County. Mary grew up in Santa Rosa and attended Ursuline High School. As part of an Ursuline student exchange program, she traveled to Mexico City, where she met her future husband Enrique González-Méndez, a young medical student. Mary then spent two years at Santa Rosa Junior College before making an abrupt break with tradition. Instead of going on to the University of California, she moved out of the country for 12 years.

Her first stop was Mexico City. There she enrolled in the National Autonomous University of Mexico School of Medicine, where Enrique was also a student. Mary and Enrique got married and later moved to Europe, living in Florence, Italy, for three years and London for two years. During this time, Enrique finished a surgical residency and Mary completed studies in nutrition at the London School of Hygiene and Tropical Medicine (University of London). They then returned to Mexico City.

After Mary received her MD from the National Autonomous University in 1984, she and Enrique moved to Santa Rosa with their two children, Catherine and Cristina. Enrique was accepted to the Santa Rosa Family Medicine Residency and Mary enrolled in the UC Berkeley School of Public Health, receiving her MPH in 1987. She was then accepted to the Santa Rosa residency, which she began the day after Enrique finished. After graduating in 1991, she worked at the Alliance Medical Center in Healdsburg and at Sonoma County's public health clinics. She became the county's public health officer in 2000, serving until 2011. For the last four years, Dr. Maddux-González has been the chief medical officer for Redwood Community Health Coalition (RCHC), a consortium of 17 community health centers in Marin, Napa, Sonoma and Yolo counties, serving 230,00 patients. This interview took place in her Petaluma office on May 25.

Mr. Osborn edits Sonoma Medicine.

The cover of this issue of *Sonoma Medicine* shows most of the physician leaders who are directing the Hearts of Sonoma project to control hypertension in Sonoma County. The physicians come from Annadel, Kaiser, Sutter, RCHC [*Redwood Community Health Coalition*], SCMA and other organizations. Could you explain the purpose of Hearts of Sonoma?

Hearts of Sonoma is an exciting collaborative on the part of all the major medical groups in our county and SCMA. Hearts of Sonoma is an initiative of the Committee for Healthcare Improvement, which is part of Sonoma Health Action. We are joining forces to significantly reduce death and disability from cardiovascular disease in our community.

Cardiovascular disease, including heart attacks and stroke, is the leading cause of death in Sonoma County and the United States. By focusing on two of the major risk factors for cardiovascular disease—hypertension and smoking—and aligning our efforts across medical groups, we can have a tremendous impact on the health of our community. We know hypertension control can be improved, and we know how to do it.

Probably the best roadmap we have right now for improving control within physician organizations is from Kaiser Permanente. A 2013 *JAMA* article described the dramatic improvement Kaiser achieved in hypertension control through organizational commitment, use of evidence-based guidelines and other population health strategies.[1] They have also seen significant reductions in heart attacks and strokes. Hearts of Sonoma is drawing upon the success of Kaiser, as well as best practices from other organizations.

What has RCHC done to control hypertension among their patients?

About two years ago, RCHC received grant funding from the CDC, through Sonoma County, to focus on hypertension. The clinical and executive leadership of our member health centers are committed to improving quality and outcomes through evidence-based and person-centered care. The health center CMOs and medical directors adopted shared hypertension guidelines across all of our health centers, which are basically Kaiser Permanente guidelines based on the recommendations of JNC-8 [*Eighth Joint National Committee*].

That was the first step—everybody buying into a coordinated and focused approach to hypertension control. Having the shared guidelines and related clinical decision support in the electronic health record made it easier for busy providers and their team members to improve blood pressure control. The default is to go to those guidelines. Each patient is evaluated individually and modifications to the guidelines are made based accordingly. RCHC has also facilitated the sharing of best practices among health centers, and we provide support for quality improvement, education and other resources.

You mentioned Sutter and Annadel. Have their physicians implemented hypertension guidelines as well?

We have excellent representatives from Sutter—Dr. Gary McLeod—and from Annadel, Dr. Eki Abrams. One of the first things we did as a group was to come to a consensus about shared guidelines, understanding that basically we are all following JNC-8 recommendations. What has been found to be effective—and certainly this is one of the elements associated with Kaiser's success—is for each medical group to develop an algorithm with specific medications that are consistent with JNC-8 but may vary slightly among groups. We are also identifying what data we can share to track our collective improvement in hypertension control.

You are also involved in the Safe Opioid Prescribing program. What is that about?

There has been a dramatic increase in the use of opioids and associated negative impacts. The United States consumes 80% of the world's opioid production. Opioids are being prescribed too often for conditions where they are not particularly effective or are provided at chronic unsafe levels. This shift in prescribing patterns over the last decade has been associated with increased risk of opioid-related deaths, as well as high levels of dependence and addiction. For this reason, the Committee for Healthcare Improvement is organizing an initiative for safe opioid prescribing.

The Safe Opioid Prescribing program will target primary care groups and emergency departments in Sonoma County. Primary care and ER, Public Health and Partnership Health Plan physicians are coming together to align their opioid prescribing guidelines and practices. The idea is to shift the community standard of practice to safer opioid use so that only those patients who truly benefit from opioids are prescribed the medication; additional pain management options are used; escalation of opioids is avoided whenever possible; and patients on very high doses of opioids are tapered off or down to levels that are safe.

Is Safe Opioid Prescribing just getting started?

Fortunately there is significant momentum across medical, public health and other organizations to address the major problem that we are facing as a county, and as a nation, with unsafe opioid prescribing. Each of the local organizations involved in the Committee for Healthcare Improvement has recognized unsafe opioid use as a problem. For example, Partnership HealthPlan, our local managed-care Medi-Cal plan, has done a tremendous amount in this area, coming out with guidelines for primary care physicians, specialists and pharmacists. We need to tackle this issue together as a medical community and local health-care system in order to be successful.

Could you talk about the more general benefits of physician leadership? How does it benefit patients and community health?

I think physician leadership is extremely important. Physicians have a unique opportunity to influence the direction of medicine and health policy. Studies show that the general public views physicians as credible and trusted sources of information. In addition, physician training and experience provide a necessary foundation for identifying effective strategies for improving care and health. The physician voice and our focus on patient-centered, relationship-based care is more important than ever given the many commercial and political influences in medicine today. Keeping the focus on the health of patients, families and our communities is of critical importance.

Nonetheless, Annadel, Kaiser and Sutter are competing organizations. Are the physicians from those groups really working together?

Yes, they are, and this is not something new for Sonoma County. I think in many ways we have an exceptional community. I saw this as health officer, and I see it now in my role with RCHC. We have an unusually collaborative community—it is a long-established culture. Everybody recognizes that our local health-care organizations operate in a competitive world, but they have come together consistently over the years for different issues to improve the health of our community. The major medical groups and hospitals have come together in a way that just does not happen commonly in the United States.

Our current health-care delivery system is highly competitive, particularly in the commercial market. That is the reality. The ability of physicians to work across their organizations in a collaborative effort to improve the health of the community is a powerful statement and a powerful force that benefits everybody.

What is your perspective on the county's greatest health problems? We hear about obesity, chronic disease, access to care. Is there one particular problem, or is it all of those things?

I do not think there is a single problem, and many of our major health issues are interrelated. For example, we have had a significant increase in chronic disease, much of which is related to how we live, what we eat and the amount of stress in our lives. We know that social determinants of health have a tremendous impact on the prevalence

Dr. Maddux-González in her office at RCHC's Petaluma headquarters

and disparities in chronic disease. We also have an aging population that is associated with an increase in chronic disease, and there the burden is higher in low-income populations.

Last year, the County Department of Health Services published *A Portrait of Sonoma County,* a report that examines income, education and health by census tract. The report shows how life expectancy varies throughout our community and gives specific strategies that we can take on as a community to improve the health of our population. We need to combine clinical and community-based approaches if we are going to be successful in improving health.

Do you think that physicians and other stakeholders in this community have the ability to solve those problems, or to reduce them? Can obesity, for example, be brought under control? Can we regulate opiates?

I think there are areas, such as safe opioid use, where physicians can definitely play a very direct role. Unfortunately, we played a big role in developing the opioid problem, but we are also uniquely positioned to fix it. In doing so, we want to make sure the pendulum doesn't swing over too far in the opposite direction, because there are some people who can genuinely benefit from appropriately prescribed opioids. We have to find the right balance.

If you look at obesity or development of chronic disease, physicians have an important role to play, but there are many societal and economic factors to consider. There is an important role for physicians in implementing evidence-based strategies in clinical practice. There is also an important leadership role for physicians in advocating for policies that reduce chronic disease by addressing the social determinants of health.

Sometimes it seems like our society is an omnipotent foe that works against good health.

That is a big part of why it is so important for physicians to align their efforts to improve health and health care with other partners with the same goal. In this way we can have a collective impact. A good example is smoking, the leading cause of preventable death. Combining the important work that physicians do in clinical practice promoting smoking cessation with physician advocacy for legislative and environmental strategies has led to a dramatic decrease in smoking rates.

Four years ago, when you were still the county health officer, you issued a comprehensive study showing that the county didn't have enough primary care physicians and needed to recruit many more. Have conditions improved since then?

Unfortunately, they haven't. Many of

the trends that we identified in the *Primary Care Capacity* study in 2011 are playing out in our community and across the nation. A large number of physicians are approaching or have entered retirement age. There aren't enough medical students and residents to meet the demand for primary care physicians. The complexity and demands of medical practice continue to increase, and physicians are often less satisfied with their work. At the same time, the need for primary care continues to grow, largely due to an increase in chronic disease associated with unhealthy behaviors and the aging of our population.

Has RCHC had any luck recruiting primary care physicians?

Most of our health centers are currently recruiting. They have focused on team-based care, which is part of the move toward establishing patient-centered medical homes. The team approach is also a response to the declining availability of primary care physicians. The approach allows physicians to use their training and skills as effectively as possible within the context of a team, rather than having everything fall on the physician.

What is the importance of the Sonoma County Medical Association in dealing with the issues we've discussed?

SCMA is important from multiple perspectives. It brings our medical community together in an organization that crosses all medical groups and practice settings. SCMA and the California Medical Association serve as effective physicians' advocates for legislative issues that impact the practice of medicine. This last year really demonstrated the power of organized medicine to come together and work with partners to influence legislation that profoundly impacts the practice of medicine. Over the course of the year, Proposition 46 was defeated, the Medicare SGR was halted and GPCI was finally fixed.

Now we need to advocate as physicians for legislation to protect individuals and communities against vaccine-preventable diseases, as well as important medical ethical issues, such as physician-assisted suicide. By being part of SCMA and CMA, physicians can bring our collective voice into this important societal discourse and the legislative process.

Despite all these impressive accomplishments, the sad truth is that SCMA membership is declining. What are the causes of that decline, and how can it be reversed?

Many factors contribute to the decline in SCMA membership. I think one important contributor is the change in medical practice patterns. For many years the dominant practice model was solo and small-group practices, and SCMA provided the opportunity for physicians to interact and work on issues across practices. Now that physicians practice primarily in large and very large groups, they tend to identify more with their physician group organization and interact primarily with physicians

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from their same group, as opposed to the broader medical community. Also, the increasing demands on physicians leave less time for engagement in other activities and organizations, including the medical association.

Do you have any ideas about how SCMA can reverse the decline in membership?
The organization has to be relevant to the needs and interests of local physicians—that is the crux of the issue. We also need to communicate that relevance effectively. I think that outreach to specific segments of our diverse medical community is an important part of assuring relevance and increasing membership. For example, I believe that SCMA membership is relevant and important for physicians from community health centers. Currently 30% of California's total population, and 50% of children in our state, have Medi-Cal, and our member health centers provide 75% of the care to the Medi-Cal population and almost all of the primary care to the uninsured. We need to ensure that the voice and perspective of community health center physicians is part of the powerful advocacy of CMA and other organizations that influence health policy related to Medicaid and the uninsured.

What do you tell your colleagues when recruiting them to join SCMA, or to retain their membership?
I tell them about the legislative achievements of SCMA and the advocacy and legislative work that remains to be done. I mention the importance of physician leadership in influencing local and state health policy. A great example is the tremendous impact of SCMA leaders—such as Drs. Len Klay, Brad Drexler and Dave Anderson—on smoking-cessation legislation. I also talk about the unique and important work we can do as a medical community to improve our community's health through initiatives such as Hearts of Sonoma. And very important also is SCMA's relationship with the SCMA Alliance and Foundation. The Alliance provides wonderful support and social engagement for physicians and their families. The Alliance Foundation has really embraced the concept of the social determinants of health and has become a major local fundraiser for these types of programs in Sonoma County.

Do you have any closing thoughts?
Just that I am honored and very excited to be the incoming SCMA president. I believe there is so much that we can do together as a medical community to improve health and health care and I look forward to working with local physicians, our colleagues and our partners to realize that potential. ◇

Email: mmgonzalez@rchc.net

Reference

1. Jaffe MG, et al, "Improved blood pressure control associated with a large-scale hypertension program," *JAMA*, 310:699-705 (2013).

"Eat an apple on going to bed, and you'll keep the doctor from earning his bread."

– *Welsh proverb, 1860s*

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A Roadmap to Preventing Heart Attacks and Strokes

Bo Greaves, MD, and Jerome Minkoff, MD

Hearts of Sonoma County is bringing together clinician leaders from medical groups and organizations throughout our community to improve management of risk factors for heart attack and stroke. This physician-led effort is off to a strong start. The leadership team meets monthly to discuss and adopt common approaches to reducing cardiovascular risk, starting with hypertension. Kaiser Permanente has done pioneering work in this area and has achieved positive results in treating hypertension and controlling blood pressure, as well as reducing overall cardiovascular risk.[1,2] After much study and discussion, Hearts of Sonoma County agreed to adopt and recommend a hypertension algorithm and subsequently published the guidelines in the Winter 2015 issue of *Sonoma Medicine*. The guidelines are based on a treatment algorithm used for the past decade at Kaiser Permanente and updated to be consistent with the eighth Joint National Committee guidelines (JNC-8).[3]

Dr. Greaves, a family physician, is medical director of Vista Family Health Center in Santa Rosa and chairs the Health Action Committee for Healthcare Improvement.

Dr. Minkoff, an internist and endocrinologist, teaches and consults in Northern California. While at Kaiser Permanente Santa Rosa, he helped develop a CVD risk reduction program (PHASE).

Since publishing the guidelines, we have engaged in productive dialog with Steve Sheerin, MD, who raised some concerns about the treatment algorithm. Dr. Sheerin is a prominent internist with Santa Rosa Community Health Centers, and he has many years of experience caring for people with hypertension and cardiovascular disease. This update briefly summarizes his feedback and questions, which likely reflect the concerns of other providers, and addresses how we have reached consensus on most of these issues.

As a general preface to specific concerns about the guidelines, we agree that individualized care is best, provided that it does not leave patients untreated or undertreated. An algorithm is simply a set of guidelines that, if followed, will achieve the desired results in the vast majority of cases. Surveys of primary care physicians, as well as nurse practitioners and physician assistants, consistently demonstrate that they value the guidance given by an algorithm, which helps ensure that clinical decisions are evidence-based and most likely to achieve the desired outcomes.

At the same time, an algorithm is not a mandate. It is incumbent upon each organization and practice to stress this point with their clinicians. Use of the algorithm should result in desired outcomes for the vast majority of patients, but individualized decisions will be needed for the small number of patients who don't benefit from the recommended treatments. Clinicians who opt for an approach that differs from the algorithm are certainly welcome to do so. The only caveat is that using a different approach should yield outcomes equally as good as the algorithm outcomes.

Questions and answers about the guidelines appear below.

Why do the guidelines list a specific medication (lisinopril) as the ACE-inhibitor/thiazide diuretic for initial therapy?

Hearts of Sonoma County agrees that this recommendation should be for a class of medications, and that it matters little which specific ACE inhibitor or thiazide diuretic is chosen. Some practices or clinicians may prefer benazepril over lisinopril. We also agree with the general principle that it is preferable for a community-wide collaboration like Hearts of Sonoma County to restrict our guidelines to drug classes and not specific medications, when there are equivalent alternatives.

Experience is clear, however, that each practice or primary care orga-

nization will do better adapting this general guideline to its own version, with specific medications identified, in order to make medication choices easiest for clinicians during a busy office visit. Another advantage of a treatment algorithm tailored to each organization is that it lends itself to developing standing orders for nurses and other mid-level providers to adjust medications or doses, which will become increasingly important as we move into an era of team-based primary care—a central feature that contributed to Kaiser Permanente's dramatic results in controlling hypertension.

Why do the guidelines recommend starting with a combination ACE-inhibitor/thiazide, rather than starting with a single med and adding the second one if needed? Some people are sensitive to this combination and will have a marked drop in blood pressure. In addition, if there is an allergic reaction or adverse effect, how will clinicians know which med is causing this?

We agree that JNC-8 allows for either starting with each single medication, or starting with a combination, as our guideline does. We acknowledge that clinicians may have concerns about potential issues with a combination start. We also note that the Kaiser Permanente experience with tens of thousands of hypertensive patients using the combination-medication guideline has produced impressive outcomes. Simplifying the regimen as clinicians titrate to reach the blood pressure goal does improve adherence.

In other words, there are convincing arguments on both sides. We agree that, in the spirit of choice embodied in JNC-8, we should modify the Hearts of Sonoma County guideline to allow clinicians to start with either individual agents or a combination. Each organization and practice will need to make those choices easy and clear for their clinicians.

Advancing the dose of hydrochlorothiazide (HCTZ) past 25 mg for treating hypertension (or for patients with ACE intolerance due to cough) rarely improves blood pressure, and the increase of side effects outweighs the potential benefit. Starting at 12.5 mg and titrating up to 25 mg makes more sense. Another alternative is to use chlorthalidone, which is stronger than HCTZ and has a longer half-life.

We agree. We also agree with adding a note that HCTZ is unlikely to be effective if the estimated glomerular filtration rate (eGFR) is less than 30.

Physicians and staff of Hearts of Sonoma County.

In the section on beta-blockers, why is only atenolol listed? Most clinicians prefer metoprolol, especially metoprolol succinate, which is taken once daily. Labetalol is another alternative. The risk level of both is Category C in pregnancy, whereas atenolol is Category D.

We agree that these medications should be listed as choices in the guidelines.

The note about women using ACEI/ARB should reflect that family physicians—not just ob/gyns—provide obstetric care, and that internists and family physicians—not just cardiologists—manage patients with heart failure.

We agree that whoever is managing pregnancy or heart failure should be notified if such patients are on potentially harmful medications.

In the table showing dosage range for antihypertensive medications, the following modifications are suggested:

- **Change HCTZ to 12.5-25 mg daily**
- **Add benazepril to the list of ACE inhibitors**

We agree.

As a result of this productive and collaborative dialog with Dr. Sheerin, we have modified the Hearts of Sonoma County Management of Adult Hypertension guidelines. We believe these changes strengthen both the guideline and the community-wide effort to reduce heart attacks and strokes.

The intent of the Hearts of Sonoma County initiative is to promote successful implementation of JNC-8-compliant hypertension management guidelines. The previously published guidelines represent one such roadmap. For specific organizations adopting and implementing the guidelines, one important best practice is to convene a group of providers who can tailor the guidelines to the workflows and drug formularies unique to that organization.

The Hearts of Sonoma County partners greatly appreciate the regular opportunity to share our experiences with implementation and to collaboratively develop strategies to benefit

Download the Hearts of Sonoma County Guidelines

The latest version of the *Hearts of Sonoma County Managing Hypertension Guidelines* is available for download at **www.sonomahealthaction.org/health-system-improvement.**

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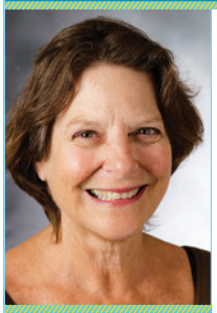

Gail Altschuler, MD
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our respective organizations. What matters most is engaging providers in the conversation and in shaping the implementation rather than adopting someone else's guidelines. Ultimately what will make the difference in preventing heart attacks and strokes in Sonoma County will be many providers and practices throughout the county collectively tailoring and implementing the guidelines.

Many thanks to Dr. Sheerin for engaging with Hearts of Sonoma County to express his concerns and help us improve our process. We all want the same thing—a healthier Sonoma County—and we are all in this together. ◇

Emails: bog@srhealthcenters.org; drjrm51@gmail.com

Hearts of Sonoma County Partners

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Northern California Center for Well-Being
Partnership HealthPlan of California
Redwood Community Health Coalition
Santa Rosa Community Health Centers
Sonoma County Medical Association
Sonoma County Department of Health Services
Sutter Medical Group of the Redwoods
West County Health Centers

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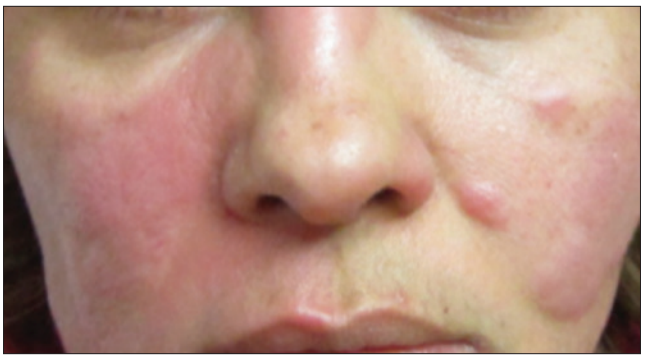
1. Jaffe MG, et al, "Improved blood pressure control associated with a large-scale hypertension program," *JAMA*, 31:699-705 (2013).
2. Yeh RW, et al, "Population trends in the incidence and outcomes of acute myocardial infarction," *NEJM*, 362:2155-65 (2010).
3. James PA, et al, "2014 evidence-based guideline for the management of high blood pressure in adults," *JAMA*, 311:507-520 (2014).

Her Face Was on Fire

Jeffrey Sugarman, MD



Note: *"Mystery Case" is an occasional department in which a local physician presents the details of a mysterious case (with the patient's consent) and invites other physicians to make the diagnosis.*

Diagnoses should be sent to the editor, Steve Osborn, at osborn53@sonic.net. The correct diagnosis, along with the name of the winning entrant, will be published in the next issues of SCMA News Briefs *and* Sonoma Medicine.

Case Presentation

Her face was on fire. At first an intermittent heat, and now a nearly constant burning pain.

Until she started developing mysterious red plaques on her skin three years earlier, the 42-year-old woman I examined last year had always been healthy. She had never been sick as a child growing up in Mexico, and in the 27 years she had lived in California, she had never had any skin problems.

Smartly dressed and attractive with perfect hair, she sat uncomfortably in my exam room. Even before a formal examination, I could plainly see the hot red plaques covering her face.

I was not the first doctor she had seen. When the rash first started three years earlier, a doctor at her clinic diagnosed the rash as poison-oak dermatitis and treated her with an intramuscular Kenalog injection. The injection seemed to help somewhat, but the rash never really resolved, and it slowly began to spread.

The patient returned to her clinic several times over the next few months and the rash was re-diagnosed as a fungal infection. She was treated with various topical and then oral antifungals, including Diflucan and Lamisil, which had no effect whatsoever on the rash. A fungal smear was also negative.

The patient lived at home with her husband and teen-aged children, none of whom had a rash. She had previously taken no medications aside from vitamins.

Her doctor wondered about chronic urticaria (hives). After all, the rash constituents were "hive-like," even though they were fixed and not fleeting in the way that classic urticaria are supposed to behave. The doctor treated her with oral prednisone and then Decadron because steroids are supposed to wipe out urticaria, albeit only temporarily. The steroids did absolutely nothing. Somewhere along the way the patient had tried and failed several antibiotics including doxycycline, possibly for presumed rosacea. They all did nothing.

Biopsy

The patient saw another doctor, who performed two biopsies of characteristic plaques on her back. These showed perivascular and interface lymphocytic and lymphohistiocytic dermatitis with occasional non-necrotizing minute granulomas. The histological diagnoses included erythema dyschromium perstans, a drug eruption, or a possible connective tissue disorder, such as dermatomyositis or lupus. Grocott's methenamine silver (GMS) and periodic acid–Schiff (PAS) stains did not reveal any bacterial or fungal

Dr. Sugarman, a Santa Rosa dermatologist, chairs the SCMA Editorial Board.

organisms. Special Fite stains performed on 10 histologic sections evaluating for leprosy and atypical mycobacterial species did not reveal any acid-fast bacilli. Polarization did not reveal the presence of a foreign body, and the small size of the granulomas did not support sarcoidosis.

Workup

The doctor who performed the biopsies ordered many tests to get a handle on this mysterious rash. The patient had a normal CBC, normal electrolytes and glucose, normal renal and liver function, and normal erythrocyte sedimentation rate and C-reactive protein test. Her Lyme titers were normal. Her thyroid function was normal. Allergy testing was unrevealing. She was the picture of health. The only positive test was for *Helicobacter pylori*. Could *H. pylori* cause a rash like this? There have been reports of "rash" with *H. pylori*. The lead was worth pursuing, so the doctor treated her with clarithromycin, amoxicillin, and omeprazole.

And then something extraordinary happened. The rash that had been smoldering for the past two years exploded. Within four months, the patient was much worse, especially on her face. The burning sensations worsened. She developed dysesthesias. Even the touch of her soft washcloth made washing her face an unpleasant experience. She ran a day-care center out of her home, and the parents of her young clients had started asking questions. What was going on with her face? She had to do something quickly.

More Biopsies

The patient was referred to a dermatologist, who was also puzzled by her progressive and recalcitrant eruption. Her skin burned and itched. Cold water didn't help. The cold water didn't even feel cold anymore. Two more biopsies were performed: one on her cheek and one on her neck. This time the pathology revealed granulomatous dermatitis, an often non-specific finding that may suggest an infectious process. But special stains looking for acid-fast bacilli, fungi and bacteria were exhaustively analyzed and were all negative.

Another Exam

When the patient was referred to me, the juicy dermal and brightly erythematous plaques involved more than just her face. Variably infiltrated plaques appeared on her trunk and extremities. On examination, I noted a finding near her elbow that prompted an additional biopsy, a phone consultation and further testing. The resulting findings ultimately yielded the diagnosis.

What's the diagnosis?

Physicians are invited to send their "mystery case" diagnosis to the editor, Steve Osborn, at osborn53@sonic.net. The correct diagnosis, along with the name of the winning entrant, will be published in the next issues of *SCMA News Briefs* and *Sonoma Medicine*.

Questions about the case should be sent to Dr. Sugarman at pediderm@yahoo.com. ◇

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Decapitated by Beauty

Rick Flinders, MD

If I feel physically as if the top of my head were taken off, I know that is poetry.

—Emily Dickinson

I spotted an empty seat at the bar, next to an elegantly dressed woman, and saw exactly the opportunity I was seeking. I took a seat, ordered a drink and introduced myself, thinking it had been many years since I had done such a thing. I was direct with my request. She had a welcoming smile and sparkling ear rings, and she was 80 years old. I asked her if she had tickets to the concert and, if so, how on earth she had gotten them.

"We bought the package, young man, and had dibs on the Yo Yo Ma tickets before they went on sale."

It was then that the slightly younger lady sitting next to her absolutely knocked me out: "Yes, we actually bought three, but our friend couldn't come. We were going to turn it in to the box office for resale, but they're not open yet."

Dr. Flinders, who teaches hospital medicine at the Santa Rosa Family Medicine Residency, serves on the SCMA Editorial Board.

I had come prepared, three hours early and with substantial cash, to try and score two tickets for my wife and me to hear one of the world's greatest living musicians, performing the solo cello suites of Johann Sebastian Bach. Failing that, I was even prepared to scale a nearby eucalyptus tree, just to hear a few notes spilling out into the evening air from the world-class Weill Hall at Sonoma State University. But my luck at the music center's Prelude bar was singular and, try as I might, I couldn't score another ticket.

I texted my wife, offering her the ticket, but she wouldn't think of it. "No, no and no," she texted back. "You go have a glass of wine, listen to the music, and then come home and tell me about each and every note."

When I got home later that night, I told her, "Honey, I think I've seen what it might have been like to watch Michelangelo paint the Sistine Chapel or sculpt his statue of David. What we heard tonight was no less masterful or perfect than a creation by Rembrandt."

It was live, in person and in a concert hall built exclusively from clear-grained European beech wood for the sound of pure music. Ma walked alone to the stage, joked with an usher, smiled and nodded to the billionaire donor who built the hall. He thanked the luthier who had performed emergency surgery that afternoon on his cello, inadvertently damaged on the morning flight from Hawaii. He explained the suites he was about to play were, for him, an expression of the feelings produced from the interaction of humans with nature. He said wine was an excellent example of humans interacting with nature. "Beautiful," he added, "and that's even before you drink it."

Ma also said that Bach was describing more than beauty in these works. The famous cellist then used adjectives such as *joyous, difficult, somber* and *sublime.* Finally he sat in the solitary chair at center stage, embraced his cello and, without speaker or microphone, filled the hall with sound, lost to language.

He played for nearly two hours,

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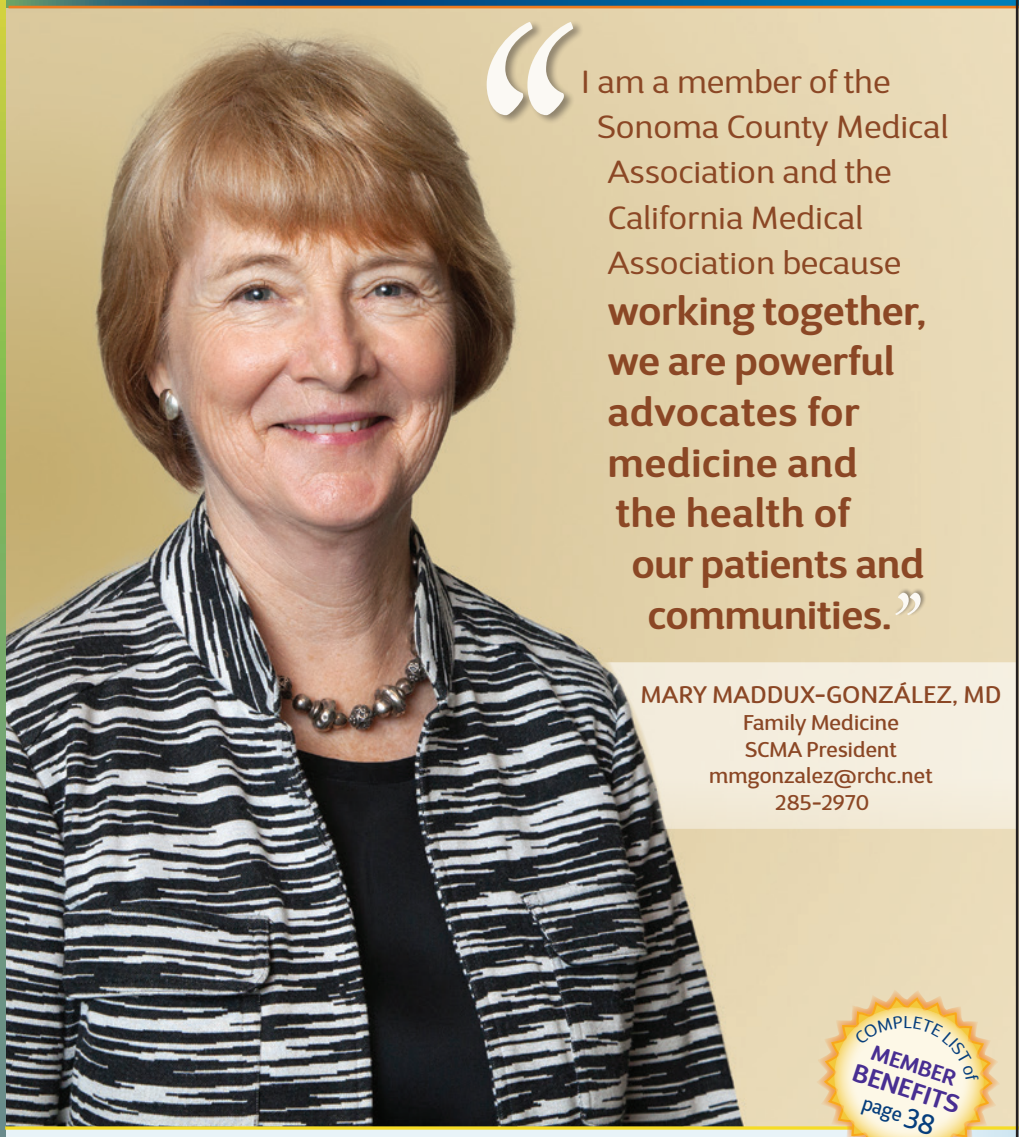

"I am a member of the Sonoma County Medical Association and the California Medical Association because **working together, we are powerful advocates for medicine and the health of our patients and communities.**"

MARY MADDUX-GONZÁLEZ, MD
Family Medicine
SCMA President
mmgonzalez@rchc.net
285-2970

COMPLETE LIST of MEMBER BENEFITS page 38

Why **COMMUNITY HEALTH CENTER PHYSICIANS** *should be SCMA/CMA members:*

1. SCMA plays a key role in initiatives that bring together local physicians and medical groups to **improve the health of our community,** such as Sonoma Health Action, the Committee for Healthcare Improvement, the My Plan/My Care advance directives project, the Hearts of Sonoma CVD risk reduction program, and the Safe Opioid Prescribing workgroup.
2. SCMA advocates for **improved access to care** for all members of our community and participates in local access programs with community partners, such as Covered Sonoma and the Specialty Access Improvement Project. Approximately 30% of Californians and 50% of California's children are now covered by Medi-Cal. Our local health centers provide care to 23% percent of the county's population.
3. Strong community health physician participation in legislative and policy advocacy **directly impacts the low-income patients and communities we serve.** To encourage greater participation in SCMA and CMA, physicians in community health centers and government entities are offered a reduced annual membership fee.

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without notation or score, every note memorized in both his brain and probably his heart, interpreting Bach as if he were telling a story he had learned and lived and developed since childhood. He is one of those rare musicians in whose hands an instrument is so mastered that it becomes an almost natural extension of the artist, his body, his voice, his entire means of expression. Such is Yo Yo Ma. He seemed transported during his performance. And so were we.

When he finished, we could only stand and applaud, and we could not stop. When he returned to the stage, he did so with cello and bow in hand. I believe it was the only way he could get us to stop. What he did next was equally moving. He acknowledged Pablo Casals, and thanked him for discovering Bach's unaccompanied suites and bringing them to the world's attention by recording them in 1920. And in homage to Casals, he played Casal's signature "Song of the Birds," commemorating his remarkable performance of the piece before the United Nations in 1971. In a world torn by rioting, assassinations and war, the aging Casals addressed the General Assembly:

"I have not performed in public for over forty years. But today I must play. This piece would have been loved by Bach and Beethoven. It is a song from my own home land of Catalan and is called "The Song of the Birds." The birds are in the sky and they are crying 'Peace! Peace! Peace!'"

When Ma finished the three-minute piece, he left the stage with no need to return. I've never been to the Sistine Chapel, nor looked upon the statue of David or seen an original Rembrandt. But like Michelangelo and Rembrandt centuries before him, Yo Yo Ma placed before us a work of decapititating beauty—and then left us with a sublime message of peace. ◇

Email: flinder@sutterhealth.org

For a video of Casals' 1971 UN performance, visit www.youtube.com/watch?v=_T8DjwLt_c4.

What the Ulcer Told Me

Matt Joseph, MD

It starts so small, the ache
just south of my diaphragm—an orchestra
warming up, a pebble
tossed at a pond, a struck match
flickering to life.

But it grows, it curls
and curls upon itself for weeks, until with every bite,
something feral and matted
is gnawing me from the inside, hell-bent
on getting out. I exhale with a snake's hiss, I swear
under my breath when it hits, and it hits
more now, harder, a mad conductor waving
his baton as a boulder crashes into the lake
whose shores are licked by flames
that reach to the moon. Hyperbole, yes,

but I'm sure I am dying. Not in the smug, sometimes flippant way
I will tell a patient, "We're all dying." No,
I am dying here, now. I know there is a cancer,
ravenous and unchecked, sending emissaries
spinning out from its spiculated mass
to stake their flags in every corner of my body.
I take the pills my doctor prescribes, tiny officers setting up roadblocks
to stop my stomach's acid, and lo! I am better. Cured.
The pain is gone. It was an ulcer, nothing more. I am immortal
once again. "We are all dying," I will say again.
Or perhaps the words will catch in my throat,
like a fish bone, and I will know that I may be dying

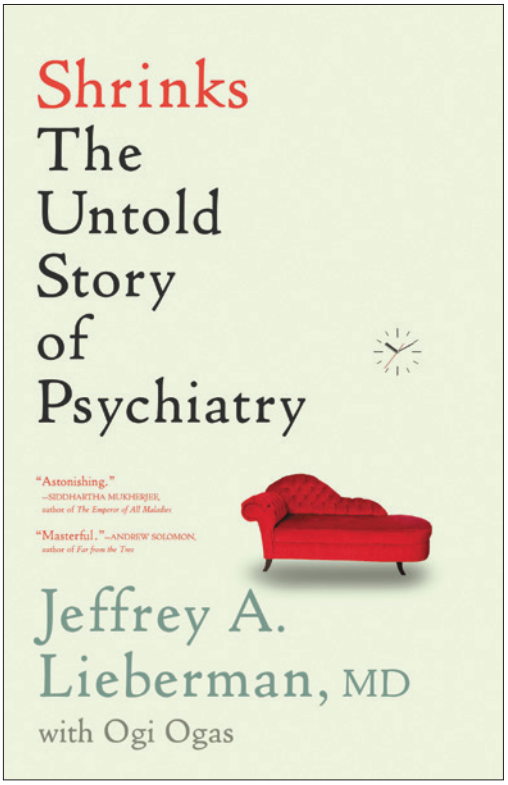
but I am not dead.
I am not entitled to tomorrow,
or tonight, even the next minute
does not belong to me by right.
All I have,
all I will ever have,
is this breath
about to grace this body
in this single,
golden moment.

Dr. Joseph is a family physician at Kaiser Permanente Santa Rosa.

From Madhouses to Modern Treatments

Allan Bernstein, MD

Shrinks: The Untold Story of Psychiatry, Jeffrey Lieberman, MD, Little, Brown, 352 pages (2015).


Shrinks
The Untold Story of Psychiatry
"Astonishing."
—SIDDHARTHA MUKHERJEE, author of The Emperor of All Maladies
"Masterful."—ANDREW SOLOMON, author of Far from the Tree
Jeffrey A. Lieberman, MD
with Ogi Ogas

As a history of a major medical specialty and a major public health problem, Dr. Jeffrey Lieberman's *Shrinks: The Untold Story of Psychiatry* raises some disturbing questions. The field of psychiatry is based on a patient's history and behavior, though histories can be creative, and behavior is typically interpreted in the eyes of the beholders, often with their own agendas. Where is the science? In an age of laboratory tests, functional MRIs, genetic markers and even pathology slides, none exist for psychiatric diagnoses. We look, we listen and we try out medications, often based on a "best guess." The current interventions, such as electroshock and transcranial stimulation, may be effective, but the underlying science remains elusive.

Lieberman chairs the psychiatry department at Columbia University School of Medicine and is eminently qualified to write this story. He has watched and participated in the evolution of the field from a Freudian-based psychoanalytic specialty to an intervention-based practice that can now identify and treat some of the most impaired people in our society.

Shrinks is divided into three parts: one historical, one on therapeutic advances, and one about the battle between the traditional Freudian analysts and the new wave of psychiatrists.

The first part begins with a review of pseudoscience, fraud and greed. People who are aware that "something is not right" will often search for answers wherever they can, and when no good answers are forthcoming, they look for promises from people who are good salesmen with dubious credentials. Mesmer's animal magnetism, Reich's orgone accumulator, and Amen's SPECT scans all offered promises of diagnosis and treatment that proved unfounded. The sole beneficiaries were the inventors themselves.

Sigmund Freud—a classically trained neurologist who studied under Jean-Martin Charcot, the founder of modern neurology—developed a theory of internal conflicts as the basis of mental illness. By slowly identifying these conflicts, much of the disturbed behavior could be treated or at least understood. This, of course, couldn't apply to people with severe degrees of illness. They were left to the backup system, which consisted of mental institutions, i.e., the madhouses. Through the first half of the 20th century, those were the two major options.

Well-meaning but poorly understood therapies abounded. People with syphilis of the brain, known as general paresis of the insane, were noted to significantly improve after running a high fever, for any reason. A "cure" was proposed to give these patients malaria since once the fever subsided, the malaria could be treated with quinine. Transient improvement was noted in some patients, but often the therapy

Dr. Bernstein, a Sebastopol neurologist, serves on the SCMA Editorial Board.

merely added one incurable disease on top of another.

A surgical technique to cure mental illness by cutting out a portion of the frontal lobe—the infamous Ice Pick surgery—was performed thousands of times, earning developer Egas Moniz a Nobel Prize in medicine. The result was a placid but hardly normal person.

Violent behavior—felt by some psychiatrists to be a focal neurologic condition related to temporal lobe epilepsy and amenable to localized surgery—was the basis of Michael Crichton's novel *The Terminal Man*. Crichton took care of these patients while a medical student in Boston, and I inherited them when I arrived as the neurology resident. The procedure involved an implanted electrode that could be used as a micro-cautery to burn out the irritable focus. The patients became less violent but also passive and paranoid. Surgery certainly hasn't given us an answer to mental illness. For a review of the thinking at that time, *Violence and the Brain*, by Vernon Mark and Frank Irvin, is still available.

Societies have always had outliers. The treatment of these people has varied, with some burned at the stake, some exiled, some shunted into religious orders and others merely locked up. The idea of locking up people for a behavioral abnormality, and not because of breaking a specific law, led to a strong antipsychiatry movement in the 1960s and 70s, led by a prominent psychiatrist named Thomas Szasz. His books *The Myth of Mental Illness* and *Law, Liberty and Psychiatry* were confrontational to the standard thinking at the time. As one of his students, I had to carefully distance myself from him when taking my oral boards in neurology and psychiatry. During the 1970s, psychiatry still had significant input from the psychoanalysts and traditionalists.

Psychiatry has evolved. With the development of medications for the most severe forms of mental illnesses, the need for locked institutions with up to 20,000 patients has passed. Of course, putting these people on the street under the care of community clinics, where they are largely unsupervised, means that a large portion of them no longer take their medications. Many homeless people would have been residents of the state hospitals in the past. Those hospitals were closed more for economic reasons than because better treatment was available in the community.

The historical section of *Shrinks* is a fascinating tale, though a little long on the details of Freud's circle of professional friends and their often petty feuds. As most readers are not psychiatrists, these details seem unnecessary. More information as to what actually transpired in the madhouses during different eras might be more enlightening. "One Flew Over the Cuckoo's Nest" is the only reference most of us have for those institutions. Having trained at one of the madhouses, Creedmoor State Hospital in New York, I could relate to psychiatric hospitals as alternative jails with no need for a judge or jury. The signature of a junior resident, whose first language was often not English, was enough to have you locked up for seven days. If two staff members signed off on it, you could be held for 30 days!

The second section of *Shrinks*—on advances in treatment over a relatively short period of time—is the core of the book. The ability to treat psychosis and severe depression has been lifesaving for a huge number of people. It has allowed people with significant mental illness to function independently and productively, which was unheard of in prior eras.

Modern psychiatry has identified post-traumatic stress disorder as a real illness and recognized severe depression as a potentially fatal disease. Diagnosis and treatment is the core of how medicine is practiced. Psychiatry is finally catching up. Modern medicines work more often than not, even if we don't quite know how. They are safer than their predecessors and cover a wider range of conditions. This review of modern treatments is the most enlightening portion of *Shrinks*.

The battle between the traditionalists and the new wave of psychiatrists—exemplified in the adoption of the DSM coding system—takes up the last portion of the book. Lieberman was involved in the process, and as the president of the American Psychiatric Association, knew all the fine points being argued. Essentially discarding the entire psychoanalytic school took courage and a lot of political maneuvering. While the details of this struggle are significant to psychiatrists, the section could have been abridged for most readers.

In summary, the road from madhouses to modern treatment of mental illness has often been rocky, but it is well mapped in *Shrinks* by a psychiatrist who watched it evolve and helped push it forward. Lieberman doesn't mind stepping on toes when needed, including a few of my old teachers and colleagues. ◇

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The Big Tent of Wellness

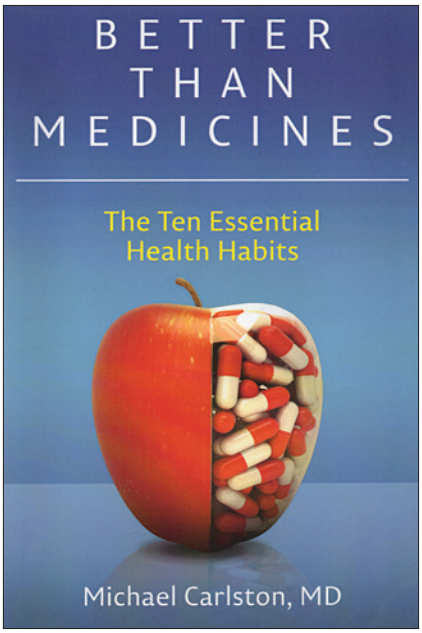
Brien A. Seeley, MD

Better Than Medicines: The Ten Essential Health Habits, Michael Carlston, MD, 352 pages, betterthanmedicines.com (2015).

The art of healing comes from nature, not from the physician. Therefore the physician must start from nature, with an open mind.
—Paracelsus

Attempting to remedy patients' failures to take proper care of themselves constitutes a large part of the practice of medicine. The failures abound largely because of ignorance, stubbornness, gullibility and laziness—in patients and, sadly, physicians. Recent societal megatrends have further contributed to the failures: the commoditization of medicine with its forced abbreviation of the doctor-patient relationship; the bewildering array of medical misinformation on the Internet; and the under-recognized perils of environmental and consumer product toxins. Failures in self-care comprise a major burden on both patients and society and are therefore of concern to all.

Happily, Santa Rosa family physician Dr. Michael Carlston has written an appealing treatise, *Better Than Medicines,* that addresses the problem of self-care with understandable and constructive solutions. In the first main section of the book, "The Ten Essential Health Habits," Carlston presents the key ingredients for habitual health and wellness in order of importance:



- Drink enough water.
- Exercise almost every day.
- Eat well.
- Take your supplements.
- Avoid the things that make you sick.
- Get enough sleep.
- Be involved in your community.
- Create a healthy sex life.
- Remember that attitude is important.
- Develop a purpose or spirituality in your life.

This section is a helpful and fairly comprehensive tract. Each habit is described in detail, with pertinent do's and don'ts and some explanation of the underlying physiology involved. They represent mainstream advice and are non-controversial.

The controversial elements of Carlston's book appear in the second section, "Consider the Alternatives." Beginning with Darwin, the last 150 years have brought increasing enlightenment about the value of diversity. Our current society embraces diversity in religion, sexual preference, music, cuisine and health care, to name a few. The cornucopia of health-related advice in bookstores and on the Internet spans everything from hogwash to rigorously tested truth. This diversity attests to our perpetual quest for good health, and to the recurring doubt as to which is the best path. Carlston's basic message is, "It's all good." Indeed, the most diverse gene pool will ultimately evolve the best solutions.

Carlston appears to be a kind and caring physician with an earnest intent to educate patients. His writing style is breezy and conversational and is clearly intended for laypeople rather than physicians. Claims about the implications or findings of one clinical study or another often lack footnotes and references, though some are provided. This oversight can be forgiven as endemic to the highly subjective domain of wellness, in which feelings and impressions are hard to quantify. Likewise, the myriad potions of compounded herbs are hopelessly too complex for controlled studies. We must accept that many therapies have subjectively nebulous and non-repeatable results that depend upon the patient's emotional state and life challenges.

This subjectivity is both the major problem with the book and its main message. Some of the arguments are thin, such as citing the long history of complementary and alternative medicine (CAM) therapies as *prima facie* evidence for their effectiveness. Unarguably, if the goal of health care is reduced to simply what makes the patient feel better, then CAM is legiti-

Dr. Seeley, a Santa Rosa ophthalmologist, serves on the SCMA Editorial Board.

mized, and it matters less whether its effectiveness derives from good listening and hand-holding rather than from presumed pharmacologic action of herbs and homeopathic solutions.

The CAM approach will likely fail to satisfy the true physician scientist, who demands a closed loop of certainty in cause and effect. The effective therapies of conventional medicine—antibiotics, anti-inflammatories, hormones, painkillers, chemotherapy, surgery—are not sufficient for a large number of subjective and chronic ailments. The effectiveness of spirit-level therapies with antidepressants and anxiolytics are likewise notoriously hard to measure and are often inadequate or less effective than CAM remedies. Moreover, the overarching reliability of good health habits can out-perform them all.

Carlston applies opinion and clinical impressions liberally, relying on his 30-plus years of clinical practice and his longstanding interest in CAM as justification for taking his word for what he says. Many portions are philosophical. Here Carlston apologizes for the lack of more definitive data or guidance, which indicates a redeeming self-awareness. However, the numerous personalized anecdotes and implied proofs of effectiveness exceed credibility when he presents homeopathy and acupuncture as legitimate science. Homeopathy and acupuncture can make people feel better, but that should not be taken as proof that the nano dosing or ceremonial pinpricking are what accomplished the wellness. Nature, expressed in human physiology, is the true miraculous healer, and physicians often err in taking credit for the cure that nature wrought.

The complex task of maintaining good health requires more than just common sense, doing "what feels right," and repeating the homilies passed down by parents. *Better Than Medicines* offers both a credible checklist of the mainstream guidelines for habitual health, along with a catalog of the most common alternative therapies. It offers abundant guidance on things to avoid as well as things to embrace. Its recommendations align well with the healthy lifestyle choices that are increasingly embraced in modern, enlightened society. It has a spirit of inclusiveness that welcomes complementary and alternative medicine into the big tent of wellness, with a helpful reminder that physicians' main purpose is to help patients feel better. ◇

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Many Faces, One Mission

Patty Lyn Tweten

The SCMA Alliance & Foundation is not your mother's ladies' auxiliary. Over its 85 years, the Alliance has become a major nonprofit player in Sonoma County, generously funding numerous public health, education and welfare organizations. How the organization has thrived while weathering sweeping changes in medicine is a story best told by its members.

Living with Purpose

When you first meet Charlene Staples, the phrase "though she be but little, she is fierce" comes to mind. She is a woman of action and accomplishment who is adored by those who know her well. Charlene has been a member of the Alliance since 1979, and has served as its president twice. She actively participated in the group's transition from a social-based women's charitable auxiliary to the nonprofit organization it is today.

Charlene witnessed the galvanic changes during the women's movement in the 1970s, when the Alliance struggled with membership. As she recalls, "Women didn't want to be seen as belonging to a frivolous group." Charlene had a different perspective. "As a feminist, I had no problem being part of a social organization," she observes. "Being active in the Alliance allowed me to enrich my life with friendship and live with purpose."

During the 1980s and 90s, Charlene watched a new kind of Alliance member emerge: one who had been out in the work force and brought those skills to the table. Newly empowered Alliance members developed more ambitious goals for the organization. The group leveraged its charitable giving by reaching outside its own membership and building partnerships with the YWCA, the public health department and other organizations. For example, the Alliance's Give-a-Gift program for children in foster care had outgrown the funding capacity of Alliance members, so the group reached out to other organizations for donations and support.

The Give-a-Gift program has recently added laptop donations for foster children headed to college. Charlene notes, "I am most proud of the way the support of children in foster care has expanded to include the teenagers who [are college bound]." She helped initiate other programs on teen issues and a seminar on physician burnout that was sponsored by SCMA.

Charlene's main reason for being in the Alliance has never changed: it is the friendships she has made and the support medical families give each other. "The Alliance is multigenerational and always has been," she observes. "It's so awesome [to remember] the women who came before and on whose shoulders we stand. I hate to think of my life without having known these women."

A Balancing Act

When Sheela Hodes joined the Alliance 20 years ago, she says it was a "no brainer." Her initial attractions were the social connections and the mutual support. "I have long-term friendships that developed and will be lifetime friendships; they started that first day," she recalls. Over the years her level of involvement in the Alliance has been balanced around her children's needs, a flourishing career in real estate, and the needs of her husband, Dr. Eric Hodes, who is currently the president of his medical group.

The annual Garden Tour was Sheela's first Alliance volunteer experience. Spending a few hours meeting new people in a beautiful garden while helping the community was a compelling enough reason to leave her kids for the afternoon. She enjoyed the experience so much that she has returned to volunteer almost every year.

Sheela went on to participate in the Safe Schools and Scholarship committees. "I really enjoy giving away money," she jokes. Her Scholarship Committee work involved reviewing applications and increased her awareness of how many deserving and hardworking students live in Sonoma County. "I especially enjoyed giving the money to them to help them with their medical careers," she recalls. She points out that her Alliance work has another upside: "My kids see my actions and place importance on [helping the] community."

A two-time Alliance board member, Sheela returned this year as the vice president of membership and has championed a successful new recruitment campaign. She laughingly describes her biggest challenge as "Encouraging people to take the leap for $75!" Happily, her profession allows her to meet physician families moving to the area,

Mrs. Tweten, a member of the SCMA Alliance, is a freelance writer and graphic designer based in Penngrove.

Past and present members and friends of the SCMA Alliance. Top row, left to right: Attendees at a 1940 SCMA Alliance dinner; Lynn C. Davis and Louanne Labbe; Laura Robertson and Shawn Devlin. Bottom row, left to right: Virgina Norman (leading fellow hula dancers in 1962); Marijke Byck; Eric and Sheela Hodes; Charlene Staples, Lisa Sugarman, Aaron Groves and Judith Hong. Photo collage by Patty Lyn Tweten.

and she notes that they are excited to find other medical people in the community. She is firm, however, about not pushing new members into roles until they're ready: "Being a part of [the Alliance] is not a commitment!" She'd rather mentor new members as they get to know the organization by inviting them to invest a few hours as their schedule permits. "Awareness is where we need to grow," she says of recruitment. "Awareness of why it's important to be a member—of who we are and what we do."

New Faces Breathe New Life

Two of Sheela's new recruits are Liz Bauer and Aaron Grove. Both are fairly new to Sonoma County. Liz and her husband, Dr. Colin Bauer, recently moved up from Marin. So far, Liz hasn't been able to attend many Alliance functions. "I want to be as involved as I can," she explains, "but I need to have more time for myself, first. I have a two-and-a half-year-old dictator at home." Sheela encouraged Liz to run a playgroup for Alliance members with young children. After a quiet beginning, Liz plans to schedule more playgroup dates in the fall: "We want to do things once a month or once every couple of months, and also keep up with things in the Alliance. This is a great way to meet new people."

Aaron Grove and his wife Dr. Judith Hong arrived in Sonoma County from San Francisco three years ago. Aaron telecommutes from home most days and drives into the city once a week. Since he doesn't work locally, the social threads that naturally occur in the work environment don't exist as much for him. He says that the Alliance "seems like a good way to get in touch" with other people in the community. He likes the organization's grass-roots level of community involvement, and he's interested to see where it will go, noting that the Alliance seems to have a lot more momentum than a year ago.

Mission: Possible

Many things about the Alliance have changed in 85 years, but two have stayed the same: the mission and the membership. The mission has always been to serve and support people and organizations in the medical field, and membership has always been for physicians and their spouses. As Charlene Staples observes, "Our friends outside the medical family really don't understand the unique circumstances of our lives." The Alliance is a community that understands those circumstances, and that is the key to its longevity. ◇

Email: patty@tweten.com

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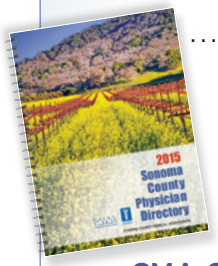

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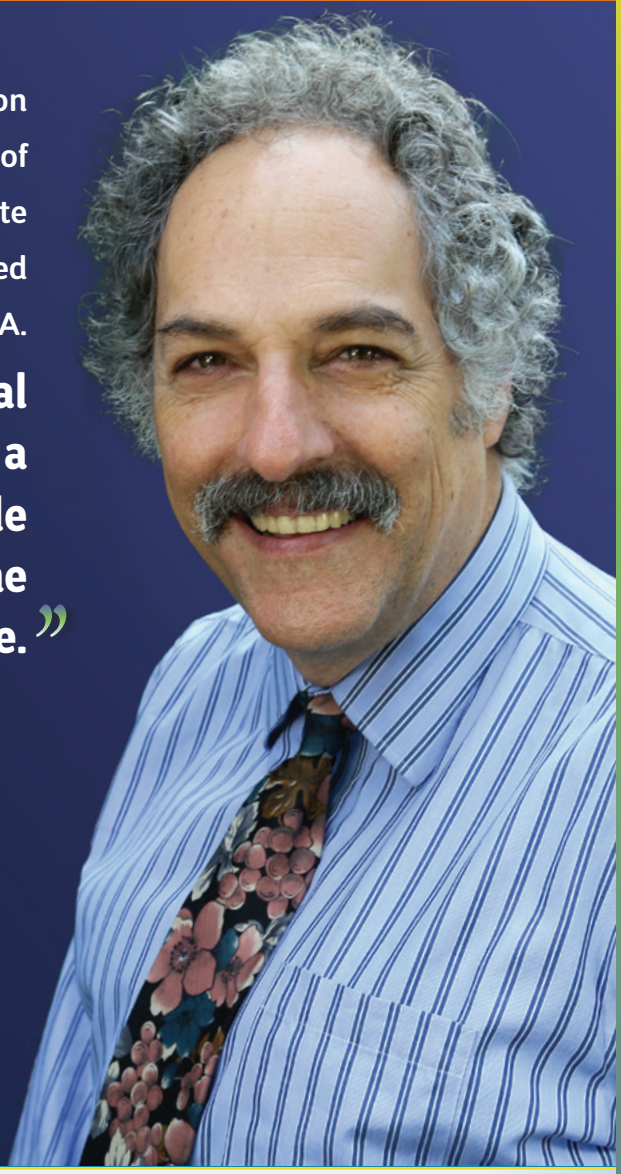

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1991	William Ellison, MD	Harry Ackley, MD	James Clegg, MD	
1992	Harding Clegg, MD Tetsuro Fujii, MD	John Reed, MD	L. Reed Walker Jr., MD	
1993	Thomas Honrath, MD	Lucius Button, MD		Helen Rudee
1994	John Sweeney, MD	William Dunn, MD	Thomas Maloney, MD	
1995	Kenneth Howe, MD	Maurice Carlin, MD Winston Ekren, MD	Leonard Klay, MD	
1996	Gary Johanson, MD Harry Richardson, MD	Michael Gospe, MD	Jerome Morgan, MD	Brother Toby
1997	Salute to Community Service	Salute to Community Service	Salute to Community Service	
1998	Gregory Rosa, MD	James McFadden, MD	Donald Van Giesen, MD	Daryl Schloss
1999	Chris Kosakowski, MD Brian Schmidt, MD	Mark DeMeo, MD	Clinton Lane, MD	
2000	Katherine Walker, MD	Frank Miraglia, MD	Cynthia Bailey, MD	Steve Osborn / Joan Chilton
2001	Jeffrey Miller, MD	Robert Huntington, MD	William Meseroll, MD	Andrea Learned / Larry McLaughlin
2002	Bob Schultz, MD	Louis Menachof, MD	Paul Marguglio, MD	Cynthia Melody / Harry Polley / Assemblywoman Patricia Wiggins
2003	Amy Shaw, MD	Brien Seeley, MD	Ron Van Roy, MD	Elizabeth Chicoine / Cheryl Negrin-Rappaport
2004	Michael Martin, MD	Jan Sonander, MD	Dan Lightfoot, MD	Sharon Keating
2005	Richard Powers, MD	Mary Maddux-González, MD		Medicare Campaign Leaders
2006	Rick Flinders, MD	Leigh Hall, MD	Lynn Mortensen, MD	Robert Pelligrini
2007	Jose Morales, MD	James Gude, MD	Phyllis "Jackie" Senter, MD	Kay Reed & David Anderson, MD
2009	Walt Mills, MD	Jeff Sugarman, MD	Brad Drexler, MD	Santa Rosa Family Medicine Residency Consortium
2010	Stacey Kerr, MD	Lyman "Bo" Greaves, MD	Richard Andolsen, MD	
2011	Allan Bernstein, MD	Enrique González-Méndez, MD	Kirk Pappas, MD	Operation Access
2012	Jeff Haney, MD	Mark Netherda, MD	Catherine Gutfreund, MD	Redwood Community Health Coalition
2013	Robert B. Mims, MD	Peter Brett, MD	Walt Mills, MD	Northern California Center for Well-Being
2014	Joe Clendenin, MD	Laurel Warner, MD Charles Elboim, MD		Ritch Addison, PhD

Save the Date!

Join us for the annual

SCMA Awards Dinner at Vintner's Inn

WEDNESDAY, DEC. 2, 2015

Watch for details at www.scma.org, in the monthly *News Briefs,* and in the fall issue of *Sonoma Medicine.*

2015 ANNUAL AWARDS

Dear Colleague:

The SCMA Awards Committee is seeking nominations for the **2015 Annual Awards,** which honor physicians who have demonstrated sustained and exemplary service. The awards, to be presented at the Annual Awards Dinner on Dec. 2, 2015, reflect a significant tribute of respect, recognition and appreciation from SCMA membership. Awards are also given to nonphysicians who have made significant contributions to the advancement of medical science, medical education or medical care. The four awards are as follows:

Outstanding Contribution to the Community (OCC)

Presented to an SCMA member whose work has benefited the community

Outstanding Contribution to Local Medicine (OCLM)

Presented to an SCMA member who has improved local medical care

Outstanding Contribution to SCMA (OCS)

Presented to an SCMA member who has served the medical association beyond the call of duty

Recognition of Achievement (ROA)

Presented to a nonphysician who has helped advance local medicine

Past recipients are listed on the preceding page. Physician candidates must be SCMA members, and may be nominated for more than one award. Please use the form below and return your nominations **by Friday, August 21.** For more information, contact Cynthia Melody at 525-4375 or cmelody@scma.org.

Sincerely,

Leonard Klay, MD
Past President and Awards Committee Chair

SCMA 2015 Annual Awards Nomination

To: Leonard Klay, MD

From: _____
(Name required)

Nominee: _____ **Award:** _____
(Use abbreviation from above)

For more than one nomination, submit separate forms for each. Please provide support information, including accomplishments and contributions, that will help the Awards Committee evaluate your nominee for the award selected. Nominations must received at SCMA **by 5 p.m. on Friday, August 21.** Submit any of the following:

Fax to **707-525-4328**
Email to **scma@scma.org**
Mail to **SCMA, 2901 Cleveland Ave. #202, Santa Rosa, CA 95403**

2015 wine & cheese reception

DUTTON Goldfield

Event hosts Dr. Loie Sauer and Dan Goldfield, winery co-owner.

THE 15TH ANNUAL SCMA Wine & Cheese Reception was held at the Dutton-Goldfield Winery in Sebastopol on Wednesday, June 10, a glorious, breezy Sonoma County spring evening. Guests enjoyed camaraderie and wine tasting. The evening closed with the ceremonial passing of the gavel and brief remarks by outgoing president, Dr. Rob Nied, and incoming president, Dr. Mary Maddux-González.

Dr. James Pyskaty and his wife, Crystal Cox; Tim Sullivan and Dr. Regina Sullivan.

Dr. Ty Affleck, Dr. David Lightfoot and Marcia Lightfoot.

Dr. Brad Drexler, Pamela Drexler and Dr. Len Klay.

Drs. Julie Pearson, Janet Pulskamp and Tricia May.

Drs. Jeff Sugarman and Tyler Gray.

Drs. Karl Greer and Amber Greer.

Charlene Staples and Dr. Cynthia Bailey.

Dan Goldfield, Dr. M. Jasmine Silva, Dr. Karl Greer, Dr. Amber Greer, Jason Tauches, Dr. Maryann Dakkak and Dr. Loie Sauer.

Dan Goldfield with Dr. Enrique González-Méndez, Dr. Mary Maddux-González, Dr. Rob Nied and Kris Nied.

Front row: Dr. Tyler Gray, Dr. M. Jamine Silva, Dr. Alice Prescott, Dr. Larry Gilbert and Ellen Gail Gilbert.

Dr. Mary Maddux-González, holding the SCMA gavel, presents outgoing president Dr. Rob Nied with his cover photo from Sonoma Medicine.

A good time was had by all.

Event photography by Will Bucquoy.

Value of Membership

PRACTICE ◆ PROFESSIONAL ◆ PERSONAL

"Physicians get busy and don't realize how valuable it is to be united.

Being organized gives us the power to deliver high-quality health care and to practice medicine in an environment that's good for us *and* for our patients."

JAMES PYSKATY, MD
Pediatrics
SCMA Board Member
james.x.pyskaty@kp.org
393-3158

COMPLETE LIST of MEMBER BENEFITS page 38

Why **PHYSICIANS PRACTICING IN SONOMA COUNTY** *should be SCMA/CMA members:*

1. There are "10 million reasons to be a CMA member" because the medical association's **reimbursement experts have recouped $10 million from payors** on behalf of physician members over the past five years.
2. CMA **faces down a slew of legal challenges** to the practice of medicine throughout the year, with issues including scope of practice, Medicare audits, peer review and medical staff self-governance.
3. **Stay up to date on health care issues** affecting Sonoma County physicians with online and print media including *Sonoma Medicine* and *News Briefs*. CMA also produces several publications for members.

Join SCMA/CMA Now! ▪ 707-525-4375 ▪ scma@scma.org

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